Delaware Health Care Commission Board Meeting

Thursday, February 1, 2018

9:00 a.m. to 11:15 a.m.

Del Tech-Terry Campus Corporate Training Center, Rooms 400 A & B

100 Campus Drive, Dover, DE

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Meeting Attendance

Board Members Present:

- Nancy Fan MD., Chair
- Secretary Kara Odom Walker, MD, MPH, MSHS
- Vincent Ryan (in place of Commissioner Navarro)
- Rick Geisenberger
- Edmondo Robinson, MD, MBA
- Theodore Becker, Jr.
- Dennis Rochford
- Janice Lee, MD.
- Kathleen Matt, PhD.

Board Members Absent:

- Trinidad Navarro
- Susan Cycyk (retired)

Health Care Commission Staff Present:

- Ann Kempski, Executive Director
- Kiara Cole, Community Relations Officer
- Eschalla Clarke, Social Services Sr. Administrator

Health Care Commission Staff Absent:

- Marques Johnson, Administrative Specialist III

I. **CALL TO ORDER –** Dr. Nancy Fan called the Health Care Commission meeting to order at exactly 9:00 a.m.

   a. **Approval of December 2017 meeting minutes –** Dr. Nancy Fan asked if the commissioners had any objections to the December 7, 2017 meeting minutes. There

were no objections to the minutes. Dr. Nancy Fan motioned to the present commissioners to approve the December 2017 meeting minutes. Dr. Edmondo Robinson second the motion, all commissioners present are in favor of approving the December 7, 2017 meeting minutes.

II. POLICY DEVELOPMENT ITEMS

- **Overview of 12-15 Benchmark Report Draft Recommendations; Secretary Kara Odom Walker, Michael Bailit**
  - Five Strategies To Reduce Delaware Health Care Cost Growth and Improve Health Outcomes
    1. Establish state health care spending and quality benchmark.
       a. Separate benchmarks for annual health care spending growth and for selected quality targets.
       b. Benchmarks set at state level, and also, as practicable, at the market (commercial, Medicare, Medicaid), insurer, and health system/provider level.
       c. Results made public, with analysis identifying underlying contributors, but no regulatory implications for exceeding the benchmarks.
       d. Spending growth benchmark to be tied to an economic index (index TBD).
       e. The HCC to hold responsibility for benchmark setting and reporting.

    2. Analyze and report on variation in health care delivery and cost and facilitate data access for providers.
       a. Develop capacity to identify cost drivers underlying performance relative to the spending benchmark.
       b. Analyze and report on variation in health care delivery and costs to identify leading opportunities for improved system performance and track progress toward reducing unwarranted and undesired variation (e.g., low-value services, potentially avoidable complications).
       c. Make information available to provider organizations to inform their performance improvement efforts.
       d. Leverage the substantial data that will exist within the new Health Care Claims Database and increasingly exists within the DHIN.

    3. Implement Medicaid and state employee total cost of care risk-based contracting utilizing alternative payment methodologies and delivery models that share risk and accountability with providers.

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   a. Leverage the State's role as a major health care purchaser to implement aligned Medicaid and state employee total cost of care risk-based contracting and thereby share risk and accountability with providers.
   b. Contracted providers will assume some financial responsibility should per capita spending exceed a contracted target.
   c. Provider financial experience will be influenced by quality performance.
   d. Initiate collaborative discussions with internal State partners, providers and managed care networks; draw upon the 2016 Delaware Center for Health Care Innovation Payment Committee's consensus paper on outcomes-based payment as a starting point.
   e. Consider how best to align with Medicare's ACO and MACRA program designs to streamline payer provider expectations.

4. Support care transformation and primary care.
   a. Strategies to increase the use of risk-based contracting must be paired with support to providers and provider organizations to ensure they can be successful under such models.
   b. Build upon the effort and resources that have been developed through the SIM process on addressing provider readiness to bear financial risk and provide technical assistance to contractors serving our population through risk-based arrangements.
   c. A priority must be placed on supporting the large number of small practices and solo practitioners, without whom system transformation cannot occur

5. Address underlying social and environmental issues affecting health outcomes and partially ameliorate them with appropriate strategies.
   a. High health care costs and poor health outcomes are only partially the result of current payment and delivery system design.
   b. Social circumstances, and environmental and behavioral factors, play a large role in health status.
   c. Providers must have the capability to serve our Medicaid and other disadvantaged populations and be prepared to address a wide range of socioeconomic risk factors, as well as comparatively high prevalence of mental illness and substance use.
   d. This strategy will require a focus on the social service infrastructure that lies outside of the health care system today.

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- **Comments from Secretary Rick Geisenberger**

Healthcare Benchmark Comments from Secretary Rick Geisenberger (Feb 1, 2018)

The Delaware Department of Finance is responsible for managing agencies such as the State Lottery Office, Division of Accounting, and the Division of Revenue that is responsible for collecting state revenue. We also have the State's Office of Economic Research and Tax Policy responsible for economic and revenue forecasting for the state.

- From 1990 to 2015, average annual U.S. per capita GDP grew at an annual rate of 3.5%. Out-of-pocket healthcare costs grew more modestly at a 2.6% annual rate.
- Meanwhile, private insurance costs grew 5.2% annually. Medicare costs grew 6.1% annually and Medicaid grew 7% annually (growing at twice the rate of the national GDP).
- Over the last 20 years, the Consumer Price Index (CPI) has grown at an average annual rate of 2.2%. Meanwhile, the State and Local Government Expenditure Deflator (the best measure of inflation that is available for the basket of goods purchased by state and local governments) has risen almost a full percentage point higher at an annual 3.1% a year – an astounding 41% higher.
- Much of this can be attributed to rapidly rising costs in health care which represent a far greater percentage of the costs borne by governments than by individuals or businesses.

How do these trends manifest in Delaware?

It manifests itself in our budget:

- Last week, Governor Carney released his proposed budget. The budget focuses on his priorities of delivering a stronger economy, safer communities, and better schools for our children, a strong and stable workforce and a healthier Delaware.
- Last year, Delaware faced a $400 million deficit. We addressed that deficit through $200 million in additional revenue and $200 million of cuts. A big driver of that deficit was that healthcare costs were continuing to eat up the budget through what the State Budget Office calls "door-openers".
- This year's budget limits our growth in the operating budget to 3.49% growth which is well less than this year's available revenue resources in part due to the revenue package that Delaware enacted in 2017.
- But state revenues going out to fiscal year 2019 and fiscal year 2020 are forecasted to grow at only 2% annually. Meanwhile, employee and retiree healthcare costs, Medicaid and other Department of Health & Social Services (DHSS) related healthcare costs are rising two to three times that pace. These rising costs along with rising public education costs crowd out every other spending category in state government (and this has been going on for the better part of the last decade).

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Rising health care costs manifests itself throughout Delaware's economy:

- According to the Delaware Department of Labor, healthcare and social assistance jobs in Delaware were 9.9% of Delaware's workforce in 2001. Today, healthcare and social assistance jobs make up 15.6% of Delaware's workforce (based upon data reported in the 2nd quarter of 2017). That's an amazing 3.4% annual growth rate since 2001 in the healthcare sector. This compares with just 0.1% annual growth in all other job categories. The bottom line is that almost all of Delaware's employment growth has happened in healthcare. Economic growth is good. But, whether it is good to have all of your economic growth occur in one sector of your economy is certainly a matter of debate by economists.

- Median and monthly employee contributions for healthcare from 2010 to 2017 experienced 5.7% annual growth.
    - Increasing from $83 to $116 a month (single plan)
    - Increasing from $316 to $443 a month (family plan)
    - Meanwhile, annual wage growth was up only 4.4% annually. So the costs for employee contributions have a full 1.3% gap. Meaning that rising healthcare costs appear to be negatively impacting wage growth.

It manifests itself in our future economic growth:

- Healthcare sciences jobs in Delaware (e.g., pharmaceuticals, etc.) are expected to grow and be the fastest growing portion of our economy through 2024 (according to the Delaware Department of Labor) forecasted to grow 1.45% annually -- adding about 6,900 jobs in the state of Delaware through 2024.
- Meanwhile, healthcare and social assistance (Delaware's largest industry sector in terms of employment) is projected to add the most jobs and have the second highest rate of growth. By 2024, one in every six jobs in the state, almost 17% of the State's workforce, will be in healthcare. The sector is forecast to add 10,200 jobs – more than twice the rate of predicted growth in our finance and insurance sector (the next largest sector of Delaware's economy).
- Obviously, healthcare is important to our economy. But one should question the sustainability of these trends and whether we have reached the point of diminishing returns. Many economists have and will continue to argue that health care cost are:
    - Crowding out investment in education infrastructure
    - Lowering total household savings
    - Increasing government deficits and borrowing
    - Reducing the competitiveness of U.S. businesses.

DRAFT

- All of this can be debated to be sure. But what stands out to me is that the rise in per capita health care costs appears to be totally unhinged from all other economic measures.
- From 1991 to 2014 (this period includes three recessions – including the Great Recession) per capita healthcare spending increased every single year. This occurred even as per capita income and Gross State Product (GSP) rose and fell with our general economy. This is not sustainable – not for our citizens, not for Delaware businesses, and not for Delaware's budget.

If anyone needs a further wakeup call, one need look no further than this week's announcement from Berkshire Hathaway, Amazon and JP Morgan Chase who announced that they would join forces to disrupt the healthcare industry by creating an independent company to cut costs for their employees. Initially, they will focus on technology solutions designed to provide higher quality and more transparent health care services at a reasonable cost. Not all that different from what we are talking about today. I for one am not going to bet against Warren Buffet, Jeff Bezos and Jamie Dimon.

I'm also not betting against Delaware's ability to address this problem and bring health care cost growth more in line with the general economy by focusing on the component parts of the healthcare benchmark outlined by the previous speaker:

1) Creating spending and quality benchmarks so we can bring transparency and attention to the underlying numbers and performance – following a cardinal rule of any enterprise – namely, "that which gets measured gets done".
2) Analyzing and reporting on variations in health care delivery and costs and making this data available to providers so we can fully understand the sources of cost growth and address unwarranted variations in costs and quality.
3) Leveraging the State's dominant purchasing power to drive the use of alternative payment methods and delivery models to ensure that both payers and providers have skin in the game and are held accountable.
4) Supporting all providers (but especially smaller providers) to ensure they can be successful under such models.
5) Continuing to combat underlying social and economic issues that inhibit good health outcomes.

My agency – the Delaware Department of Finance – through our Office of Economic Research and Tax Policy – looks forward to partnering with the Health Care Commission and DHSS and others to help develop this benchmark.

We believe it is critical that any such benchmark be tied to verifiable measures of economic growth that are transparent and independently generated – perhaps leveraging the highly regarded processes that have been used by the Delaware Economic and Financial Advisory Council (DEFAC) for more than 4 decades now to set the State's official revenue forecasts. The DEFAC process draws upon the expertise of economists, industry and government subject matter experts while simultaneously structured to prevent any one interest group or industry from determining the outcome. Specifically, we believe that a benchmark should be tied to what is going on in the broader economy – not merely in healthcare --

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both here in Delaware and the region -- measures such as gross state product, personal income growth, wages, employment, inflation and the like might all be considered in setting the benchmark.

There may be no more important initiative within the Carney Administration for the future health of our economy, our citizenry and our finances than this work we will undertake together. So I look forward to working with all of you as we embark down this path.

Public Comment

Wayne Smith (Delaware Healthcare Association) – the state government has not done a great job in benchmarking the state employee participation. Note that the numbers that you provided [Rick Geisenberger] do not provide the whole picture.

Rick Geisenberger (in response to Wayne Smith) – the state deflator numbers that I provided were nationally, not Delaware specific.

John Dodd (from Sussex county) – Is the migration of people over the age of 65 good or bad for the economy? Also, is the tourism in Sussex, Rehoboth and Bethany – is that good for the economy and what percentage of it is?

Rick Geisenberger (in response to John Dodd) – That model works really well in Florida that has a sales tax. It could be debated if it's good for Delaware which **does not** have a sales tax. A book distributed by the Department of Finance called the **Tax Preference Report**. The last decade this book has tried to address the issue of structure of the state's personal income tax. This has been a challenge for us.

- **Public Comment on Benchmark Report**
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- **Health Care Claims Database data access rule; Jan Lee, MD.**
  - Overview: Promulgated the final regulation in October 2017 on data collection
    - Directly effects the payers that will be the reporting entities
    - DHIN took public comments and the final regulation was reported in October 2017 – so far there is only one signed data submission and use agreement.
    - Data Access Regulation
      - DHIN promulgated a proposed regulation in the December register – Commissioners received the proposed regulation as it was published in December (handouts provided to the commissioners) they can also be found on the DHIN website here: https://dhin.org/healthcare-claims-database/.
      - Public comment period remained opened through January 16, 2018. There was a total of 37 recommendations/comments received.

DRAFT

- By statute, DHIN is to stand up a healthcare claims database committee from the DHIN board or a sub-set committee thereof. The committee has been formulated out of the DHIN board and have a minimum of members assigned to the board. There is room for more members we will continue to add members to the Healthcare Claims Committee.
    - A working group was established from the DHIN committee to work with DHIN's consultants, Freidman Healthcare – to draft the data access regulation and to vet through public comments that DHIN received.
    - The working group includes the following:
        - Meredith Tweedie (Christiana Care)
        - Jeff Hofoff, MD (Beebe)
        - Steve Lawless, MD (Nemours)
        - Ann Kempski (Health Care Commission)
        - Brenda Lakeman (State Employees Benefits Office)
        - Jan Lee, MD
- The two documents together – draft regulation as it was published and the matrix of public comments (handout to the Commissioners) will allow you to see what DHIN is proposing to accept and not accept based on the suggestions made in the public comments.

- The language of the statue specifies that DHIN will promulgate form and content of applications to receive data in collaboration/consultation with the Health Care Commission. In order for DHIN to publish the final regulation in the March register, Dr. Jan Lee must turn into the registrar an order to publish and final regulation not later than February 15, 2018. **Commissioners to provide their recommendations well before the deadline specified above**.

III. DE INNOVATIONS

a. United Medical Medicare ACO; Kemal Erkan, CEO (PowerPoint Presentation can be found on the DHCC website here: http://dhss.delaware.gov/dhcc/files/kemalerkanpresentation.pdf)

- Changing Behavior for Efficient Population Management

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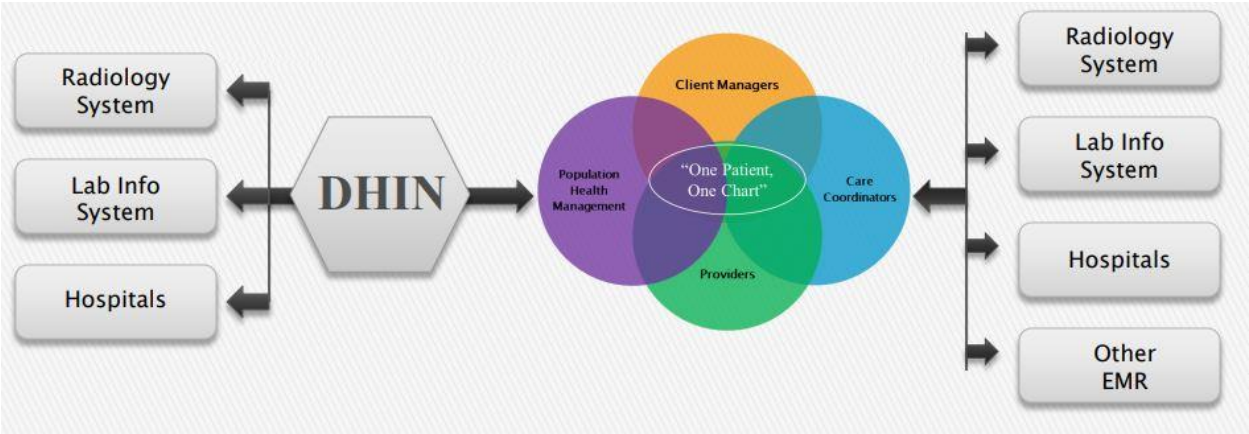
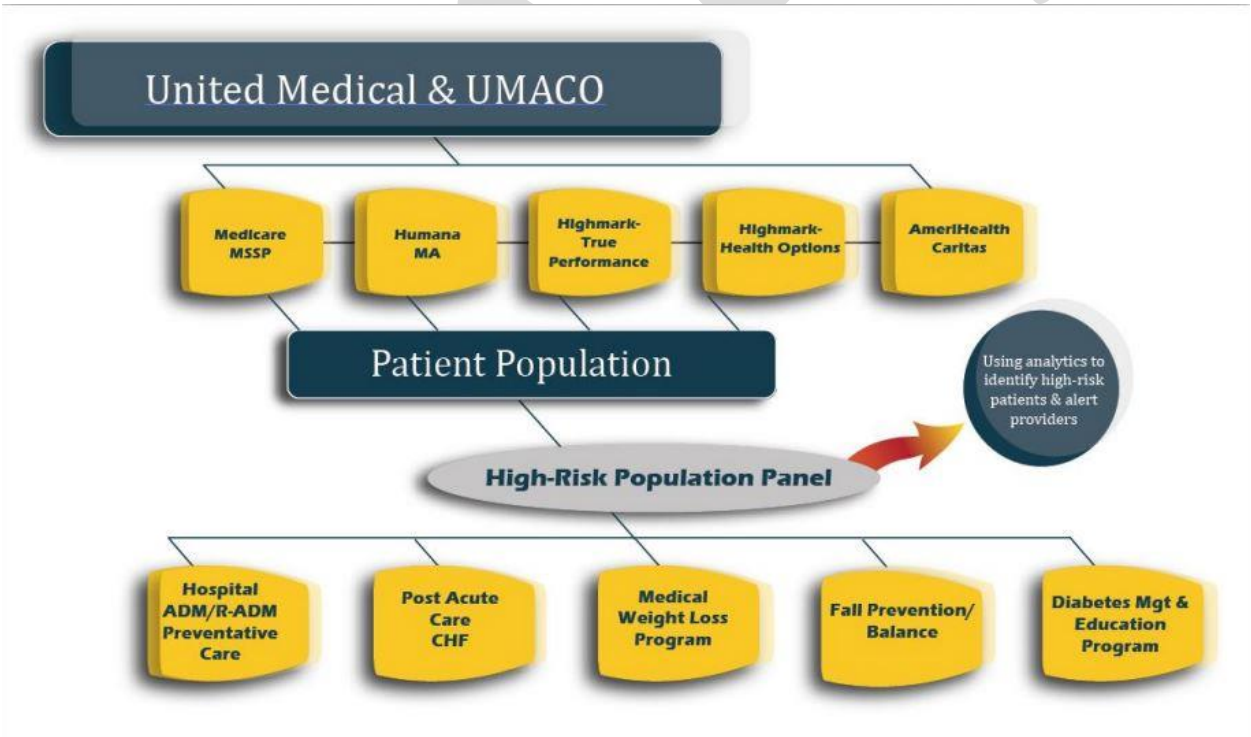
United Medical Community Model



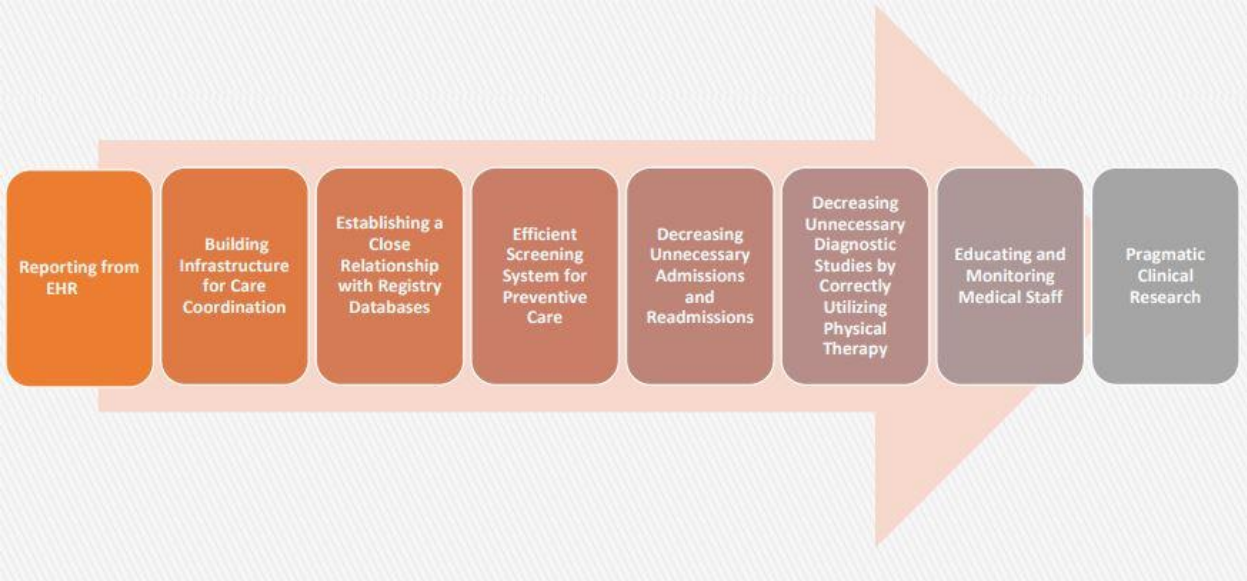
- Logical Domain (One Patient, One Chart) Uniting Over 180 Providers and More Than 325,000 Patient Encounters

Different ACO Programs Under ONE ACO Platform



Value-Based Contracts

UM's ACO Focus Points: The Last 5 Years



Physician Engagement Model:

<u>"Citizenship" Measures</u>

- Monthly ACO Meetings:
    - North (New Castle County);
    - South (Kent/Sussex Counties)

- Monthly Webinar with Practice Managers

Goal:

- Streamline Approach to Performance Metrics Management
  - Cost & Utilization
  - Quality Metrics
- Regular Monitoring & Reporting
- Subject Matter Expert Presentations

Participation:

- Mandatory for All Providers and Office Managers

Cost and Utilization Management

Focus on what you can control:

1. Implementing an Efficient Screening System for Preventative Care
2. Decreasing Unnecessary Admission and Readiness
3. Decreasing unnecessary diagnostic studies by correctly utilizing physical therapy services
4. Monitoring and educating the medical staff on utilization of generic vs. brand medications

Please see the PowerPoint presentation at this link for statistics provided by speaker Kemal Erkan: http://dhss.delaware.gov/dhcc/files/kemalerkanpresentation.pdf.

IV. UPDATES: ACTIVITIES & INITIATIVES

- **Marketplace Summary OE 2018; Nancy Fan**
  - Quick snapshot of where we are and where we have been (view PowerPoint slides here: http://dhss.delaware.gov/dhcc/dhcc_presentations2018.html)
    - Patients were able to still maintain their access to Medicare
    - Hopefully, we will have a deeper update on more demographics regarding who was enrolled and who was not re-enrolled at next month's Health Care Commission meeting.

Public Comment

Rick Geisenberger – I am hoping that in a stack chart format, it will show the automatic re-enrollments.

Nancy Fan (response) – I am not sure that we will be able to get the statistics of who was actually crossed walked across the plans from CMS – but we will inquire about that to see if we can retrieve that information.

Nick Moriello – the other relevant piece of data to retrieve from CMS is if we have a concern about how many people reenrolled subsequently in the previous year.

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- **DE CHIP Update; Secretary Odom Walker**
  - The re-authorization of the bill passed in January 22, 2018. This bill expands funding until 2023.
  - There are 8,300 children and their families covered by CHIP.
  - Nationwide CHIP covers about 9 million kids.
  - CHIP costs Delaware about $30,000,000 a year and the state portion is $2.9 million.
    - We are able to leverage significant state funding to conduct this program.
  - Shifting to how we get re-authorization of funding for our community health centers. Delaware community health centers serve about 50,000 patients. Nationwide there are about 26,000,000 people who are served by community health centers.
  - Federally Qualified Health Centers receive about $5.1 billion in federal funding each year; about 70% of its operating revenue and the remaining 30% annual congressional appropriations.
- **SIM Update (Year 4 Plan); Ann Kempski and Health Management Associates**
  - Year 4 SIM rests on a lot of work in previous years (1,2 and 3)
  - Strategic approach to the original SIM grant – our plan rests on that – putting more emphasis on some of the drivers like payment reform.
    - Population health programs
    - Practice Transformation
    - Behavioral health
- **Health Management Associates (Lisa Whittemore)**
  - There are 17 practices signed up from cohort 1 – 40/50 locations across the state
    - 5 BH providers; 12 primary care providers
    - Officially began on January 1, 2018
  - Access issues – child psychology
  - Kicking off a learning collaborative at Dover Downs on February
  - Recruiting practices for the second cohort (beginning in July)
  - Working closely with DHIN to create Common Scorecard
  - DCHI clinical committee to review and provide feedback on the work that HMA has been doing
  - Creating a behavioral health work group
- **Health Neighborhoods Initiative for Delaware (Liddy Garcia)**
  - Year 4 – all about rapid implementation
    - Getting the money down to the neighborhood taskforces
    - Implement community based initiatives – at the same time providing sustainability post SIM grant

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- Readiness assessment tool
    - Data
    - Evidence based initiatives
    - Community buy-in
    - Budget
    - Outcomes
- Healthy Neighborhoods Committee
    - Has decided to continue to meet for the purpose of sustainability – HMA will support the committee.
- Healthy Neighborhoods Consortium
    - February 22, 2018
    - Sounding board to ensure initiatives are aligned
    - Representatives of the local councils, United Way, Blueprint communities, etc.
    - Learning collaborative – sharing each other's successes
- Year 4 budget and operational plan is approved by CMMI
    - $5.6 million

V. PUBLIC COMMENT

- Lolita Lopez – Westside Family Health
    - Federally Qualified Health Center funding is in jeopardy on The Hill
        - DE should be on red alert as 70% of funding will be lost – this will affect the safety net.
        - Right now, a bill to fund FQHC's is nowhere to be found for passing legislation.

VI. ADJOURN – Nancy Fan adjourned the meeting at approximately 11:05 p.m.

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